

# **INDUCTION TO NARRATIVE MEDICINE**

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1<sup>st</sup> April 2007**



# Induction to Narrative Medicine

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## INDUCTION TO NARRATIVE MEDICINE

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## 1. INTRODUCTION

I once read in a magazine that you can tell you're really communicating when you struggle to find the right words. This idea has come to mind countless times over the years. It raises a thousand questions, such as, "What is it, exactly, that I *am* putting into words?" "What is so special about this kind of communication between people?" "What is the equivalent for listening?"

This experience, of struggling to express something in words, is common to most people. This whole book is, in fact, made from such struggle, it is about this struggle, and it celebrates and honors this struggle, as a critical moment in human experience. I offer you a deeper, closer look, as if it were the hands-on, molding clay of all healing, creative acts.

For some of us there is an intense synergy between the words 'healing' and 'creative'. Many artists find their skills therapeutic, and many therapists (occupational, physio-, psycho- and educational therapists, for instance) use art and creativity to achieve healing progress. But the combination of the healing and the creative is nowhere else as powerful as in the relatively new field of Narrative Medicine.

What is Narrative Medicine? In what follows I hope to both tell you and show you, having come at it myself by both living it and by practicing it as a medical specialist. One way of describing it is that you harness the struggle of putting things into words and hook it up to the technical know-how of scientific

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medicine. It occurs in the safe container of your doctor's office. There is much more to come about what Narrative Medicine is, but unless described carefully, it is so simple it disappears.

What happens between a patient and a doctor is unlike any other bond. A medical doctor is legally required to practice science-based, state-of-the-art medicine, yet the oath young doctors take is still to Apollo, a pre-Christian god of healing, light, poetry and music. While many of us disclaim the addressee of this oath, we would all hopefully agree that the knowledge and skill of the best doctor in the world is useless if a patient cannot connect and make use of what is offered. Narrative Medicine is a way to make conventional medicine work better.

I use the words 'doctor' and 'patient' for clarity, but there is less difference between the two than we like to think. You are warmly invited to continue. The text assumes you do not have a medical background, but simply a human one, with some experience of suffering and pain.

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## 2. INDUCTION

Talking one-on-one, there are many levels of communication going on. You see and hear each other, but also smell and feel. You sort, judge, emote, recoil and lunge, verbally and figuratively. So two patients coming in with the same problem can be guaranteed to have completely different interviews, and it makes sense that a doctor's spoken treatment pathway for that particular problem varies from person to person, pitched to where each one should get it. A lot of this happens without being aware of it. Regrettably, writing a general book with this kind of intimate, moment-to-moment signaling between writer and reader is not possible, and any one format will not work for everyone.

How to proceed? By *induction*. The word 'induction' first appeared in the title of this book by accident, intended as the book was to be an 'introduction' to Narrative Medicine. Induction, though, beyond being a pun, has a rich variety of meanings with poetic utility, because it turns out that Narrative Medicine is hard to explain. Simple word definitions don't work, as I've found out by trying. It requires having the listener *experience* a shift, a transition or a transformation of sorts, to convey what I'm getting at.

Even if I knew precisely *who* I was writing to, conveying this experience shift as a *doctor* and *in words* is hard to do. Sure, novelists, poets and writers of all sorts do this all the time, quite easily, in the form of dramatic effect. Any form of art should do

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this. But if you think about it, there's a fine line between achieving a desired dramatic effect and blatant psychological manipulation. When you approach something and see it as "art" there is a built-in willingness to experience its effect on you; you open yourself to psychological manipulation from the work of art. Art is neither good or bad; it's there to show you something new. When you go to a doctor, however, dramatic effect is unexpected, inappropriate and potentially damaging. Most people are sensitized to being "lied to" by doctors, health media and health-related industries. Doctors, on the whole, are "matter of fact", scientific, evidence-based, logical, legally registered, police-screened, publicly accountable, hounded and re-certified. A lot. Some doctors' personalities are easier to get on with than others, but intense creativity, originality of expression, and emotionally invasive, culture-shattering impact are not in the job description.

How is it, then, that they *can* reach out to you, help you and establish a trusting bond with you? Well...by doing two things at once. For instance, there are certain sounds in the French language that don't exist in English. You learn them by doing two things at once. Try this: say "ee" with your throat and "oo" with your lips, and you get "u" as in "tu" (*you*, familiar). The "ee" and "oo" stay separate, but work at the same time to create the new sound. Native French speakers do this from infancy and are unaware that it's hard.

In Narrative Medicine, there are two things happening at once. To simplify it, you could say that one is "science" and the

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other is...what. Art? Heart? Love? Feeling? Compassion? Co-suffering? For a doctor-scientist to even describe or decide what this other thing *is* – is totally non-scientific, hard to put into numbers, not amenable to measurement and proof. Science and heart, from a science perspective, must *never* mush into one thing. They are allowed to work together; the heart things are *said* to be important: but do *not* bring this up at an annual scientific meeting, thank you. We're doctors, not... not... Picasso? Mother Theresa? Yet medicine without love is cruel.

So, back to *induction*. The French lesson was an example of induction, of showing by example, of living and acting out the thing being taught in words, in order to make a verbal/logic idea into a physical, body-felt understanding. This body-based knowing is called *intuition* by some. And training your doctor to access intuition would require Picasso himself, in person!

Not really. Helping science to harness compassion requires the reassurance of *induction*. In electrical physics, induction is a process by which a body having electrical or magnetic properties produces electromagnetic effects in a neighboring body without direct contact. Science can co-exist with compassion and not lose its strong identity or its power.

In formal logic, *induction* is the opposite of *deduction*. In deduction, you start with all the facts and arrive at a strong conclusion that *has* to be also true. (If  $a = b$  and  $b = c$  then  $a$  *must* =  $c$ .) Science is built on deductive reasoning. But human beings aren't completely predictable, and doctors actually use

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*induction* a lot, it may interest them to know. Induction means that while you might start with a set of particular facts, there are way too many to know them all, and you have to weigh in the observational evidence in favor of a particular conclusion. This conclusion says something is true about the whole class of facts, but it's based on just some of them, the ones that are humanly available. Doctors do this all the time and are comfortable with it. So some doctors may want to approach art-ideas as simply much more inductive, much harder to prove, but not without their own kind of validity, nevertheless.

Induction also *does* mean introduction in a literary sense. An “induction” is a beginning unit in a literary work, a prelude or a scene, but independent of the main performance, not related to it. Chapters two through four are, in fact, such units – the real definitions of the narrative within medicine start in Chapter 5.

But I want you to have this experience first: *imagine you are going slowly down an escalator, perhaps into an underground subway. As you descend, it gets less light, slightly warmer, and you are counting backwards from ten to one.* This visualization is actually an *induction* to a meditative or hypnotic state.

And one final use of the word induction, perhaps the most familiar one. In physiology, or the science dealing with how the body's organs work (its companion word is anatomy, what things are called) induction is a process where one tissue stimulates or alters other adjacent tissues. Sometimes this is done artificially for medical reasons, hence the artificial initiation of labor in pregnancy

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is *induction*. (As in: “Yes, I was two weeks overdue so they induced me but nothing happened so I had an emergency Cesarean...”)

The ultimate purpose of this book is to reconfigure your own pain and suffering in a creative, new way, with a body-felt certainty that there are healing and wholeness in your present and future. This type of creativity already exists within us. I am “inducing” you into labor – a good labor, a process of bringing this skill out of long-repressed, deep embodiment.

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## 3. BODY. METAPHOR

The human body is amazing and beautiful. If you have eyes to read and hands to hold a book, you have a body through which you experience life.

Is the human body the metaphor for everything we think? It's a tempting idea. "I see what you mean." "You saved my hide." "This is a pain in the neck." We use a base-ten number system, learned on ten fingers. We tend to think in opposites, one in each hand. "On the other hand, you realize, she was a leftist hippie..." We express strong emotions by referring to the bodily sensations they stimulate: "Her face just burned." "There was a knot in my throat." I've made a game of listening for new body metaphors when I'm bored around people. I'm struck when a good writer creates new language that fits me like skin.

Like induction, where something is gotten across from one side to another, the word metaphor, from the Greek *metaphora*, means *a transfer*. A metaphor is a figure of speech that is applied to something it isn't really like, in order to suggest a resemblance. Metaphors slip in and out of language like fish.

Attention to metaphor is important. Unlike the deductive, logical argument that wants to *prove* something, the inductive, metaphor "argument" wants to *show* something, to make a point. While convincing and moving, metaphors are

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just metaphors, they are not logical, evidence-based truths. (Knowing the difference is 'clear thinking'.)

And as we know, the medical profession sticks to what is logical and evidence-based as far as is humanly possible. One is tempted to brush this aside as boring, rigid and self-important. This is my own professional community and even I feel like this. But in order to explain what Narrative Medicine is, I ask you to experience "both sides", the doctor's and the patient's.

On behalf of the doctor, pretend I'm a combat-zone reporter, "live from the front". Just yesterday I sat with a friend in the doctor's lounge of a teaching hospital, where the discussion turned to "medical students these days", always more hopeless than we were. But how hard it is, to transform a young man or woman into everything we expect a doctor to be; to mold logic, judgement, clear thinking and a blinding, shifting mass of scientific information into the nice person who listens. It takes decades of focused apprenticeship, both from the students themselves and from the countless other doctors they have contact with for the rest of their lives. Yes, medicine is learned from books, but a large spleen isn't a large spleen until you touch one and you *know* it. Inside there's a "wow!" Some colleagues do seem to get it from reading, and look brilliant on bedside teaching rounds. Some of us struggle with mere words and need to *experience* the facts.

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Finally, at some point, “you’re on your own”. You know you’re right or wrong, beyond what a teacher says, and without an answer key at the back of the book. Often, the right answer for what to do right now is off in the future, dependent on how a patient happens to respond. Nerves of steel and a stomach of iron come in handy.

From the patient’s side: need I say? We all know. We have all had experience with health professionals and some have had more than their share. Not only do we each have a unique history of life in a human body, we’ve had a one-of-a-kind sequence of health conditions. We have a “relationship” with Medicine, vague but tangible, built from just being over time. When suffering and pain are involved, this easily becomes a negative relationship. If someone has an overwhelmingly negative relationship with medicine, it may be delivered directly to me, and I accept it, to help in the present.

Does this always happen? No, it’s an ideal standard of practice. Does the language exist that would guide all doctors and all patients toward idealized, healing encounters? Unlikely. Is there something beyond language? Something beyond the noise of the body, beyond the intangible aspects of being a human being for which language itself may be a metaphor? Something universal and obvious?

Well...silence. Peace. Waiting. The pauses between the words. The time-windows of “nothing” in the dialogue between two people, where each is alert and highly aware,

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struggling to formulate things into words. These pauses need to happen. They cannot be pushed or edited out.

The four walls of the room where you are (or the curtains, or the tree) create a space, a shared container in time. Awareness of peace and silence get beyond body.metaphor and contain it safely. This awareness comes from doctor, patient, or both. This can happen in an inner-city trauma bay, eleven o'clock, Saturday night.

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### 4. VIOLENCE. PAIN

Pain is meant to tell you to take your hand off a hot stove, or not to walk on a broken leg. Pain usually indicates a problem in progress, either tissue damage or tissue healing. Not all pain resolves, however, and if no underlying cause can be identified and treated, then regardless of cause, the pain itself becomes the problem.

Chronic pain is a curse of human existence. The patient continues to suffer, the doctor is impotent, and failure can suffocate all that was good. This is the extreme case, and perhaps, to exaggerate further to make a point, smaller versions of this occur all the time, whenever more is expected and less is achieved.

Here I found myself, loving my work, listening intently to amazing life stories. A common pattern in patients with chronic pain, and with chronic fatigue as well, is that they were doing fine until some particular event occurred, often minor, but from which they never recovered. Usually lots of tests are done by general practitioners and specialists before I meet them. People get frustrated, start to believe it's all in their head. But again, regardless of cause, the pain and the fatigue become the problem, a final common pathway to many things gone wrong.

*Then*, if you start probing gently, it often transpires that these same people have a history of abuse or violence,

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some type of trauma, unusual childhood experiences or periods of instability during life. The existence of *post-traumatic stress disorder* is largely accepted, as a psychiatric entity, but placing pain and fatigue in this spectrum is not usually done. One of the reasons for this is that there is often a large gap of normalcy before the pain and fatigue are “turned on” by the minor event – the virus, a small car accident, a divorce or death in the family. And haven’t we all been traumatized by now?

The causality from life trauma to chronic pain and fatigue is highly controversial, from the scientific medical view. Please reread that sentence three times. But there *is* evidence for it. It is, to date, observational, anecdotal and circumstantial evidence. And it does, chronologically, seem to be the case for many. Insisting to that person that it *isn’t* the case, *that the experience they have lived through is false*, does, indeed, put their “sanity” at risk.

Time passed and I found myself extracting more and more honest, blunt, at times horrible stories. At what point I decided to let the pain and fatigue of the present become metaphors for past trauma I’m not sure, but the telling of the present and past became the same thing, and the present could not progress without a new, compassionate hearing of the past. This approach spread to all of my patients, including the ones with identifiable, treatable illnesses. The trauma-hearing was quite specific and took no extra time.

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But it came at a cost. I started writing, first poetry and then complex narratives, and soon enough I met my own trauma history. If I was to believe in my patients, then I had to accept that my own past was worse than I thought. I was stunned. I have had twenty-five years of robust, curiosity-driven psychotherapy, and I managed to avoid seeing this until my mid-forties. The floor fell out.

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### 5. POWER. NARRATIVE

The material in this section is far from exhaustive. It is selected and streamlined to get the general ideas across. This is the definition section I mentioned earlier.

A **narrative** is just a story. Even children know what stories are, and that's the point. There is something elementally human about the act of telling stories and we learn it quite young. A formal definition of *narrative* can be this, from Walter Fisher (1984). *A narrative is an interpretation of some aspect of the world that is historically and culturally grounded and shaped by human personality.* This material sounds academic, and frankly, it is. It is found, however, in Wikipedia, on the internet, which is available to anyone with net access. Wikipedia can be changed by anyone, regardless of status, gender, color, creed or religion.

In semiotic theory (or, the study of signs and symbols, especially those of social relevance) *all texts*, whether spoken or written, *are basically the same*, except that some authors encode their texts with distinctive literary qualities to distinguish them from other forms of discourse. *All texts are basically the same.* This to me means that a scientific presentation and the ramblings of a decompensated schizophrenic *are*, at least on one level, *the same*. In other words, they are each narratives from a human being, both

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stories, but with different coding. All *texts* are basically the same.

Then back to Walter Fisher again, and *Fisher's Narrative Paradigm*. This idea claims that *human beings prefer to shape information as a story*. In other words, people retain everyday information as anecdotal narratives with characters, plots, motivations and actions. Pay attention to your brain doing this sometime. It is especially noticeable when you have been hassled and you anticipate telling someone else about it. "*All the lights were red, then there was a train, then construction, and then, you wouldn't believe it, he has the nerve to say to me...*"

Once you get this far, it is not a surprise that there is a field called *Narratology*. The anonymous authors of this Wikipedia section say this term was first used, in French, by Todorov in 1969. *Narratologie*. This means, "*the theory and study of narrative and narrative structure and the way they affect our perception.*" This is a good time to take a break. Have a drink of water or coffee.

The next level is **Narrative Therapy**. This is a form of *psychotherapy*, which arose in the 1970's and 1980's, in a collaborative effort between Australian Dr. Michael White and New Zealander Dr. David Epston. It focuses on the story telling aspects of human communication, particularly in the psychologist's office or the primary carer's office, where a G.P. is doing psychotherapy (it happens, for very good reasons).

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Narrative Therapy is in international usage, from academic levels down to grass-root, lay-person support group settings. It is a *constructivist* practice, as opposed to an *empirical scientific* one. It says that *people can change their pasts by the stories they tell in the present*.

And then finally, you get to **Narrative Medicine**, or, medicine practiced with narrative competence; the ability to recognize, absorb, interpret and respect the narratives of both patients and caregivers. Narrative Medicine wants to know *how stories work* and *what work stories do* in the sphere of medicine.

Narrative Medicine is attributed to Dr. Rita Charon, of Columbia University, New York City. Graduating from Harvard Medical School in 1978, she finished her internal medicine training in 1982. She realized early on, in her own words, that “what people paid me to do was to listen to extraordinarily complicated narratives, narratives with words, gestures, silences, tracings, images and physical findings”. She went on to get a PhD in the literary analysis of these narratives. What was a topic of interest within the medical humanities became Columbia’s Department of Narrative Medicine in 2000.

Rather than ask a million questions as doctors are trained so well to do, Dr. Charon states simply, “I’m going to be your doctor, so I need to know a great deal about your body, health and life. Please tell me what you think I should know about

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your situation.” She writes down the patient’s answers, using their own words when possible, while they are changing into exam drapes. When the interview is done, she photocopies the material and hands it to the patient, as a concrete, ritual act that the event has occurred. From the very beginning, a very different type of dynamic and bond is formed.

The hypothesis here is that by increasing our narrative competence, we increase our empathy, our ethicality and our effectiveness.

This process sounds simple enough, but I tell you, it is an enormous paradigm shift that boggles a mind trained over decades to be a conventional physician. We have no time! We are medico-legally duty-bound to perform up to a standard of care! And yet, and yet, and yet...it makes human sense. It is humane, humanitarian and humbling.

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### 6. BECOME CREATE

If two things always occur together, you may never know they exist separately. Imagine a life-long lunar eclipse, suddenly shifting apart. *Become.Create* combines two principles coming together.

*Become* represents the Socratic idea that “we are all in the process of becoming”. Life is chronologically linear and we are never the same from moment to moment. *Create* reminds us we have the power of art, of narrative (and the power of making new life, as living organisms.) We change the past by the stories we tell in the present. *Become.Create* suggests we construct and re-construct our present self, again and again.

For a narrative to *become.create* in a narrative medical sense, it requires a speaker and a listener. Yes, you can “speak” alone. Writing is effective and strongly encouraged. But even when you write, “someone is listening”, whether it be another part of self, a projected-imagined other, or a sacred Other. In Narrative Medicine, the narrative is by definition occurring in a medical context, and it is used to gain insight into the medical problems of a whole person. In the room, the container, of a medical encounter, *the intentions and quality of the listener* become very important. The listener is *with* the speaker and *both* are keen to know what arises

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from the struggle to find words. The struggle is “contained” in the shared silence of permission and expectancy.

So let's return to that rare space of struggling to put things into words, of finding that the words we need don't exist. Stay there. If there are strong physical sensations, acknowledge them. You don't *know* what will happen. This is where Narrative Medicine starts, I think.

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